1. PURPOSE

Mercy Services aims to ensure best practice falls prevention and management strategies to minimise risks of falls and fall related injuries.

2. WHO DOES THIS POLICY APPLY TO

This policy applies to all Mercy Services staff, visitors and volunteers

3. POLICY

- Mercy services will endeavour to enable clients to remain independent as long as possible and will take reasonable steps to educate and prevent clients from experiencing falls.
- Coordinators will provide brochures, booklets and other educational material to the client and their family/significant others regarding fall and injury prevention, if appropriate. Information should be offered in languages other than English if requested.
- Where falls occur Mercy Services aims to provide appropriate response and action to prevent a reoccurrence.
- Clients to be advised when commencing service with Mercy Services that unless there is an Advanced Care Directive recorded in the client record, Mercy Services will contact Emergency Services if there is concern for the health of the client such as a possible head injury following a fall.
- Mercy Services Post Fall Protocol is to be followed at all time. This is to be recorded in the client file and an incident form completed. If the client refuses to participate, this is to be recording in the client file and incident form completed.
- All Community Transport client are to be considered a High Falls Risk.
- Falls Risk Stickers are to be placed in the client record of appropriate persons. Alert created on Carelink
- High risk clients encouraged to have an emergency alert system such as Vitalcall for their home

4. PROCEDURE

4.1 *Establish environmental interventions to prevent falls*

- The Client Home Environment Checklist is attended at the initial assessment and informally on regular home visits to identify environmental risks at the client home. Coordinators will address any risks that need corrective action such as:
- Ensuring staff have easy access around the areas they need to work and to equipment and assistive devices;
- Client education on environmental risks such as loose throw rugs, frayed carpets, cords/wires, poor lighting and encourage the client to remove these risks.
- Encouraging an Occupational assessment to assist with mobility aids including handrails, ramps etc.
- Encouraging use of emergency monitoring systems such as Vitalcall etc.for assistance in emergencies

- Mercy Services venues are assessed using the Workplace Checklist by WHS representatives and corrective action taken on any identified falls hazards at Mercy Services campuses.
- Coordinators are responsible for ensuring that public venues are assessed using the Public Venue Checklist for suitability for the clients and proposed activity.

4.2 Identifying those at risk of falls

Coordinators will use the Falls Assessment and Management Plan (MSAC02) to assess Home Support Program/National Disability Insurance Scheme (HSP/NDIS) and HCP clients for falls:

a) on admission; and
b) following a change of physical status and
c) after a fall.

Where observed risks of a client falling are identified the Coordinator will formally discuss these with the client and/or their GP and other authorised person e.g. Enduring Guardian. The Coordinator will record the decision regarding further action on Falls Assessment and Management Plan (MSAC02).

Coordinators will document actions they have taken to identify and respond to falls risks in file notes. Coordinators will add to the Care Plan any falls prevention actions that have become part of the ongoing service. Any steps to prevent falls are added to the client's Care Plan and reviewed at least annually.

Falls Risk Stickers are to be placed in the client record of appropriate persons. Alert to be created on Carelink

Staff and volunteers are instructed to inform their Coordinator if they think clients have physical/mental conditions that could increase the likelihood of a fall.

4.3 Preventing falls by individuals

Coordinators and staff will encourage clients to:

- Engage in appropriate health checks and education. For example, use of antihypertensive medications for clients with high blood pressure.
- Appropriate continence management
- Engage in functional activities and make referral to Day Centres, Falls Prevention Clinic etc. that can assist clients with physiotherapist prescribed exercise programs, progressive resistance training, and/or strength and balance programs;
- Use of mobility aids;
- Use of protective devices where these are prescribed by GP or Occupational Therapist/Physiotherapist; and/or
- Attend regular medication reviews with GP and take medications as prescribed including Vitamin D and/or calcium supplements.
- Wearing appropriate footwear
- Wearing glasses or other vision aids if required even around the house.

Coordinators will provide brochures, booklets and other educational material to the client and their family/significant others regarding fall and injury prevention, if

appropriate. Information should be offered in languages other than English if requested.

Mercy Services staff are vigilant as to risks such as: unlit spaces, clutter, pets, use of rugs, need for grab bars, wet floors, use of wax on floors and needed repairs to surfaces as well as changes in physical symptoms. Additionally, staff ensure clients attend medical appointments and use the clinical skills of registered staff nurses when needing support.

Mercy Services staff member will report to their Coordinator if they have observed behaviours that could indicate the client has had or might have a fall. The Coordinator will then review the client's likelihood of a fall and/or ask about the frequency, context and characteristics of their fall/s. Where the nature of the Mercy Services care service has limited personal care or client support duties the Coordinator will discuss with client/client's GP/client's family their concerns regarding the clients falls risk

4.4 Response to falls

- Mercy Services staff will follow the Post Falls Protocol at all times following notification of a fall.
- The falls and actions taken will be recorded in the client's record and an incident form completed.
- If the client refuses to participate in Post Fall Protocol, this is to be document clearly in the client record.
- Once the client is healed, Mercy Services staff will encourage her/him to stay active, build their muscle strength and regain her/his confidence. Throughout this process Mercy Services staff will reinforce directions given to the client by their treating doctor.

4.6 Risk factors indicating potentially significant mild head injury

- GCS <15 at 2 hours post injury ∂
- Deterioration in GCS
- Focal neurological deficit
- Clinical suspicion of skull fracture ∂
- Vomiting (especially if recurrent) ∂
- Known coagulopathy / bleeding disorder
- Aged >65 years
- Post traumatic seizure
- Prolonged loss of consciousness (>5min)
- Persistent abnormal alertness / behaviour / cognition **
- Persistent severe headache **
- Large scalp haematoma or laceration **
- Known neurosurgery / neurological deficit **

**Clinical judgement required by Registered Nurse

4.7. Education

Mercy Services will provide training to relevant staff on falls prevention and response. These sessions will be evaluated and any necessary changes made as a result of findings.

Coordinators will provide brochures, booklets and other educational material to the client and their family/significant others regarding fall and injury prevention, if appropriate. Information should be offered in languages other than English if requested.

4.7 Reporting falls and tracking trends in falls

All falls are to be recorded on a Mercy Services Incident Report Form, analysed and discussed at the Risk and Continuous Improvement Committee. This results are minuted and available for staff to read. Education can be provided if required at targeted areas.

5. KEY PERFORMANCE INDICATORS

All care staff attending SWP - Accompany client on a walk & Assisting client to move from or into a chair
All High Falls risks clients have alerts in Care Link and a falls risk sticker in their hardcopy file.
Yearly participation in Clinical Excellence Commissions April Falls Month

6. EXPECTED OUTCOME

Mercy services aims to increase client awareness of falls prevention and provide appropriate care in the event of a fall whilst respecting the client rights.

7. DEFINITIONS

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. - Preventing Falls and Harm from Falls in Older People Best Practice Guidelines for Australian Hospitals 2009

8. REFERENCES

NSW Health Policy Directive – Falls, Prevention of Falls and Harm from Falls among Older People: 2011-2015 (PD 2011_029)
NSW Health Policy Directive – Initial Management of Adult Closed Head Injury (PD2012-013)
Clinical Excellence Commission – Post Falls Assessment and Management Guide for all adult patients, June 2013
CEC-Post-Fall-for-Community-Care-260515.pdf

9. OTHER RELATED POLICIES OR PROCEDURES

E.20 Responding to deterioration in client health

10. VERSION CONTROL AND CHANGE HISTORY

Version	Date Reviewed	Amendments
1.0	4.5.18	E.18 Falls Prevention Policy archived .New policy developed

POST FALL PROTOCOL

Special precautions need to be taken for Clients known to be on anti-coagulant medications such as ASPRIN OR WARFARIN or who have known bleeding disorders.

FALLS AND DOES NOT HIT HEAD AND/OR CLIENT REPORTS FALL

- Initial First Aid
  - Response
  - Send for help
  - Airway
  - Breathing
  - Circulation
  - Does the Client have an **Advanced Care Directive?**
- Attain information about fall from client and assess for potential injuries
- Attend Baseline vital signs: BP, heart rate, respiratory rate etc. (*if trained)*
- Call 000 for Ambulance if required.
- When safe to do so, contact coordinator and advise of situation.
  Coordinator to:
  1. Notify family/person responsible. Request a support person stay with client to ensure they are ok
  2. Notify GP
  3. Gain consent from the client to make referrals to appropriate services for falls risk assessment and management if required
  4. Document and communicate
  5. Attend incident report
- If no signs of injury
  1. Warn the person/family/carer of delayed signs: dizziness, blurred vision, headaches, confusion (disorientation, agitation, restlessness and changes in behaviour - be alert for head injury), sudden onset of pain or new pain, inability to weight bear.
  2. .Advise them to contact their GP and/or ambulance if any of these signs develop

FALL - POSSIBLE HEAD INJURY CLIENT CONSCIOUS

- Initial First Aid
  - Response
  - Send for help
  - Airway
  - Breathing
  - Circulation
  - Does the Client have an **Advanced Care Directive?**
- Assess for potential Injuries and reassure client and family (if present)
- **Call 000 for Ambulance for assessment**
- Attend Baseline vital signs: BP, heart rate, respiratory rate etc. (*if trained)*
- Neurological Observations, inclusive of Initial Glasgow Coma Scale (GCS) (*if trained)*
- Administer First Aid
- Continue baseline vital signs and neurological observations (GCS) in 5 minute intervals and document
- When safe to do so, contact coordinator and advise of situation
- Coordinator to:
  1. Notify family
  2. Notify GP
  3. Document and communicate
  4. Attend incident report

FALL - CLIENT UNCONSCIOUS (MEDICAL EMERGENCY)

- Initial First Aid
  - Response
  - Send for help
  - Airway
  - Breathing
  - Circulation
  - Does the Client have an **Advanced Care Directive?**
- Assess for potential Injuries and reassure client and family (if present)
- **Call 000 for Ambulance**
- Attend Baseline vital signs: BP, heart rate, respiratory rate etc. (*if trained)*
- Neurological Observations, inclusive of Initial Glasgow Coma Scale (GCS) (*if trained)*.
- Administer First Aid
- Continue baseline vital signs and neurological observations (GCS) in 5 minute intervals and document
- When safe to do so, contact coordinator and advise of situation
- Coordinator to:
  1. Notify family
  2. Notify GP
  3. Document and communicate
  4. Attend incident report

OBSERVE CLIENT OVER NEXT 7 DAYS FOR CHANGES IN BEHAVIOUR OR LOSS OF CONSCIOUSNESS

Get medical advice immediately if any of the following are observed or reported:

- **Severe persistent vomiting**
- **Drowsiness, giddiness of confusion (new or worse than Client's normal)**
- **Severe or persistent headache**
- **Bleeding from the ears or nose**
- **Drowsy or difficulty in waking up (new or worse than Client's normal)**
- **Feeling or acting as though drunk without consuming alcohol or drugs**
- **Confusion or not acting normally**
- **Convulsions (fits) or persistent twitching of face or limbs (new or worse than Clients normal)**
- **Seeing double**

A REVISED FALLS RISK ASSESSMENT SHOULD BE ATTENDED FOLLOWING A FALL